

# SUMMERS (J. E.) Jr.

## [Clinical Lectures]<sup>al</sup>

1. *Amputation at the Shoulder Joint.*
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6. *Hæmorrhagic Hydrocele.*
7. *Double Club-Foot and Hand.\**

\*SURGICAL CLINIC, CLARKSON MEMORIAL HOSPITAL, OCT. 13TH, 1894.

... AND ...

*Two Cases of Intestinal Surgery in which the  
"Murphy Button" was Used.†*

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BY

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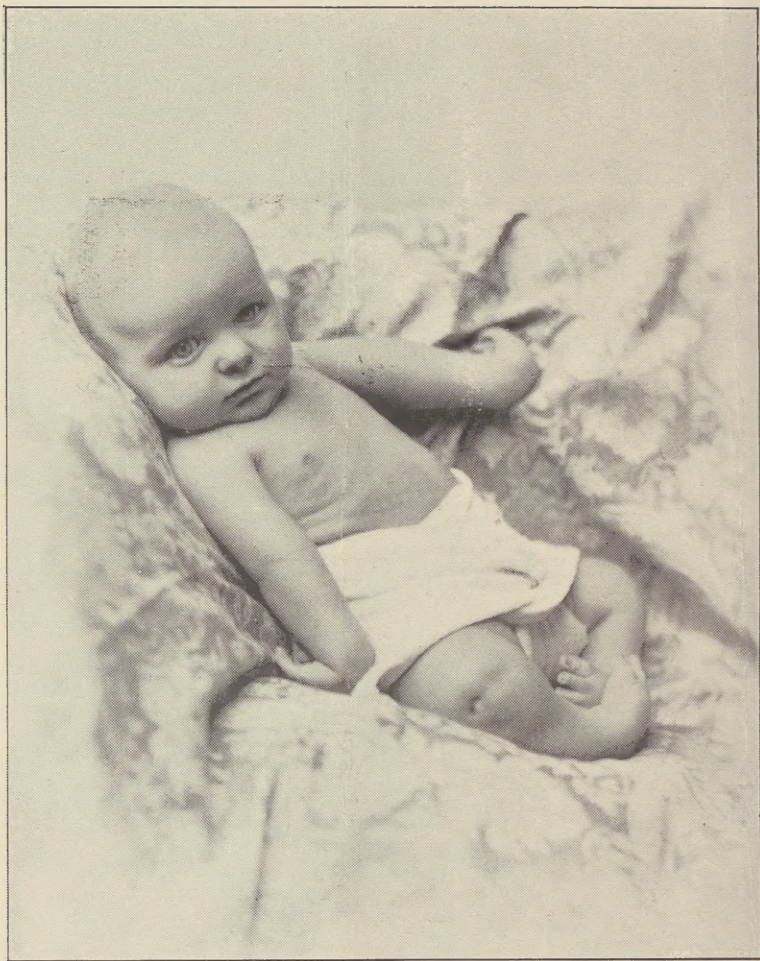
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DOUBLE CLUB HANDS AND FEET.

## CLINICAL LECTURES

BY J. E. SUMMERS, JR., M. D.

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Before commencing our operations for to-day I desire to show you the woman whose right arm I severed at the shoulder joint one week ago, and also several other instructive cases operated upon since.

I. *Amputation at the Shoulder Joint.*—The shoulder-joint operation was done to remove a useless member which was the seat of extensive suppuration, resulting from an operation for the removal of an enormous sarcoma situated in the axilla. In the manipulation for the excision of this growth, although no ligatures were thrown around either the axillary artery or vein, yet in some unaccountable manner the arterial circulation was shut off and as a result the nutrition of the limb threatened: this happened some seven weeks ago. Immediately after this operation gangrene threatened, several sloughs formed, especially one large one just below the axilla, resulting in destruction of a considerable area involving the median nerve for some four inches. As the woman was losing ground from infection it was determined to remove the limb, notwithstanding there were slight evidences of the sarcoma in the neck. This was done by what is known as the Larrey method, and to-day she is so much improved as to be able to sit up. It is very mortifying to be compelled to resort to so mutilating a procedure, yet it is just and right when a life is at stake.

Always explain such matters fully to the patient and friends, and do not delay in doing so until nearly all chance of success has passed; have the knowledge to recognize the inevitable result of procrastination and the courage to act.\*

II. *Stricture of the Urethra with Extravasation of Urine, Perineal Section and Supra-Pubic Cystotomy.*—This young man was sent to the hospital by Dr. Allison last Sunday morning. He had had a stricture of the urethra for several years which had narrowed the calibre of the canal to such an extent that micturition was slow, painful and difficult. On Saturday afternoon while trying to urinate he had felt something give away in the perineum and from that time until seen by Dr. Allison, Sunday morning, he had suffered greatly from inability to urinate and an increasing swelling in the perineum which was beginning to involve the scrotum and penis. As a temporizing measure the doctor aspirated the bladder above the pubis and then sent the patient to the hospital for operation. Several hours after admission I saw the man and found the bladder visibly distended, the perineum bulging and scrotum and penis swollen and slightly œdematous. All of these indicating that, with the first history, there had been a rupture of the urethra behind a stricture in the immediate neighborhood of the bulbo-membranous portion. The anterior layer

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\*The sarcoma returned in the neck with great rapidity, and being judged inoperable, the woman was advised to return to the hospital where treatment has just been begun with the injection of the mixed toxins of the bacillus prodigiosus and erysipelas.



of the triangular ligament must have been torn through because the inflammatory symptoms following the extravasation, *i. e.*, the swelling of the perineum followed shortly by involvement of the scrotum and penis, showed that the rupture could not have occurred in the membranous urethra alone, *between* the two layers of the triangular ligament, as it requires considerable time more than a few hours, for this to take place. Had the rupture occurred in front of the anterior layer of the triangular ligament, the symptoms of extravasation would have made themselves evident in the scrotum and penis prior to the swelling in the perineum. After the parts were carefully prepared the patient was placed in the lithotomy position and a staff passed, which was arrested at the site of stricture. A free incision in the middle line of the perineum exposed the end of the staff and evacuated a considerable quantity of foul-smelling, purulent urine. Although a painstaking search was instituted the proximal end of the urethra could not be located, and deeming a more prolonged manipulation harmful and apparently futile, the patient was placed in the Trendelenburg position and the bladder opened by a free supra-pubic incision. A sound was then passed from the bladder through the prostatic urethra into the membranous portion and the proximal end of the urethra located, the sound was withdrawn and I then gradually passed my index finger from the bladder through the urethra meeting the index finger of my

other hand in the perineal wound. A large soft catheter was then passed from the meatus of the penis into the bladder, the wound in the bladder partly closed, and a drainage tube introduced. The abdominal incision was closed to the lower angle where an iodoform gauze drain was placed, the perineal section was lightly packed with iodoform gauze.

Since the operation the man has done exceedingly well and there is every prospect of a speedy recovery. He was ordered quinine and salol (gr. v) each every four hours until the second day when the interval between the doses was increased to six hours. The catheter has now been removed permanently and is only introduced every six or eight hours for the purpose of removing such urine as is not readily drained out through the supra-pubic opening, and the bladder is irrigated morning and evening with a warm boracic acid solution. The perineal wound is granulating and will probably close in another week or ten days and I intend to allow the incision into the bladder to close as soon as it will, which will be perhaps three or four weeks from the time of operation. I consider the digital dilation from within the bladder was good practice as it relieved all spasm of the sphincter and simply reversed the method we use when we open the membranous urethra, pass a finger into the bladder and then drain the bladder through the perineum for some old inflammatory conditions of the bladder.



III. *Tracheotomy for Foreign Body in Trachea.*—This little boy, 3 years of age, while eating some watermelon seeds got one down “the wrong way.” He was seized with violent coughing and symptoms of suffocation, but these passed away—this was two weeks ago. From the time of the accident until four days ago, when he was brought to this hospital, there had been a number of attacks of spasmodic breathing with more or less continuous dyspnoea. Phonation was good, indicating that the foreign body was probably not in the larynx. Both lungs seemed to expand equally, but there were present the usual symptoms of a catarrhal pneumonia in the upper half of the right lung; temperature 102° F. Believing that the melon seed was impacted over the bifurcation of the trachea, possibly in the right bronchus, a low tracheotomy was done, but I was unable to reach it with any instrument at hand. Discovering that respiration was *not* greatly improved by the introduction of a tracheotomy tube I passed a silk thread through each side of the wound in the trachea, fastening their ends together behind the neck and gave instructions that if respiration became difficult to have the tube removed entirely and the silk threads tightened so as to cause the opening into the trachea to gap and give all room possible for respiration and the expulsion of the seed. On the second day while the nurse was cleansing the inner tube the little fellow was seized with an attack of coughing and expelled the foreign body through the larger, outer one. The

tube was then removed permanently and the threads tightened in order to rid the trachea of the irritation of the tube and at the same time give free vent to the copious secretion of mucus. To-day the temperature is normal, the wound will close by granulation in a few days and the child can be taken home. Many foreign bodies in the trachea can be expelled by the efforts of nature, especially if of a metallic kind, but, whatever their character, no delay should be allowed, if symptoms of a threatening nature are present, in opening the wind-pipe below, if possible, the supposed site of the body. In older children and adults most foreign bodies in the larynx and upper part of the trachea can be removed by the intra-laryngeal method, provided there is plenty of room for respiration.

IV. *Hæmorrhage Following Castration.*  
—This young man had his left testicle removed five days ago for sarcoma of that organ. In tying the pedicle catgut was used. On the second day after operation I was summoned hastily, the message stating that the patient had been suffering severely for several hours and that the parts were swelling rapidly and very dark in color. On examination the whole scrotum was found enormously enlarged, and almost black; this condition extending into the anterior portion of the perineum below and the penis above. The drainage tube was blocked up. Recognizing at once that the ligature applied to the pedicle had slipped and that an active hæmorrhage was in pro-

gress and responsible for the swelling, the patient was anesthetized and the wound into the scrotum opened and enlarged upwards; numerous huge clots were turned out and the bleeding vessel clamped and ligated with silk. Free incisions into the penis and right side of the scrotum allowed of the expression of considerable quantities of blood and serum. The wounds were dressed for drainage, protection and support, and to-day from the mildly swollen ecchymotic appearance of the parts you would not imagine such an alarming state of affairs had been in existence. I show you this patient in order to call attention to the possibility, following the supposedly secure ligation of blood vessels, of hemorrhage, and also to caution you. This is the first time that I recall such an accident in my practice, although I am in the habit of using catgut for most ligations, except for ligations in continuity of very large vessels as the external iliac (two cases), and the securing of pedicles in pelvic surgery.

V. *Hæmorrhagic Hydrocele*.—The first patient who presents himself to-day for operation is a negro, 55 years old, who tells us that he has a very much enlarged scrotum which has been tapped many times during the past nine years of its existence. Two weeks ago an injury happened to the part, since which time the swelling has increased to the size you observe, nearly that of an adult head. On examination we observe that the swelling is on the right side, more or less elastic and feels as if its contents were semi-solid, and there is no trans-



lucency—the usual signs of hernia are absent—we have probably to deal with a hæmorrhagic hydrocele. After the usual precautions, I introduce a trocar and withdraw a considerable quantity of dark-colored blood through the canula, and it is now very easy to detect semi-solid masses within the scrotum which can only be clots: these must be removed by incision. Injecting a few drops of a four per cent. solution of cocaine along the line I wish to incise, the scrotum is opened painlessly and the clots washed out. There has been some lamination around the whole tunica vaginalis and as I attempt to spoon this off the patient complains of intense pain—it is more fright than pain—but we will give him a little chloroform. After removing all of the laminated clot the much thickened tunica vaginalis is sutured to the skin along the line of incision through both, and a gauze and rubber drain introduced. This is the only operation applicable in such cases, and I believe it the best in all chronic cases of hydrocele because the thickened condition of the tunica vaginalis will not admit of a cure by any injection treatment.

VI. *Hæmorrhagic Hydrocele*.—This man, a German, 35 years of age, comes to us for operation. He also has an enormously distended scrotum on the right side which gives all the signs of hydrocele except translucency. The enlargement has been in existence some years, but has never been operated upon. Under cocaine anæsthesia the usual incision is made and

the fluid you see escaping is evidently blood, but not of recent formation, there is a thick fibrous lamination about one-half inch deep and so strongly attached to the tunica vaginalis that it is separated with considerable difficulty. I will treat the wound as in the last case. You observe the man has complained of very little pain, and I do not think there has been much. Of late I am getting to use cocaine extensively in such cases and prefer it to general anæsthesia in operations for the radical cure of varicocele by open incision and excision of the veins as it can be made absolutely painless. I have even made this week, besides another painless operation for hydrocele, a castration for cystic degeneration of the testicle with no complaint of pain, the cocaine acting like a charm in both cases.

VII. *Double Clubbed Hands and Feet.*—The patient I now show you represents a rare and interesting condition. This infant is six months old and was born with the deformities you observe; one, the double club foot of the equino-varus variety is a very common condition, the other however, a change in the natural relations of the hand to the forearm at the wrist joint, is uncommon and interesting. This latter deformity may be in flexion or extension with or without radial or ulnar deviation, the most common form is flexion. Our little patient has this latter variety with also some ulnar deviation. The cause of this deformity is usually accounted for by the supposed abnormally small quantity of

liquor amnii; the pressure theory. When as sometimes happens, there may be a deformity of the bones of the forearm or even absence of the radius or of the bones of the carpus, it is theorized that this is due to the pressing of the amnion to the skin in the early periods of gestation causing attachment and local obliteration of the bone-forming elements. Acquired club-hand is due to the same causes as the same variety of club-foot with which you are familiar. On examination we find no bone deformity, and although there is considerable rigidity, yet there is quite a range of motion, but the deformity is reproduced so soon as we cease our efforts to bring either hand into its normally straight position. The muscles involved are usually the superficial single flexors of the wrist, viz: the palmaris longus, flexor carpi ulnaris, flexor carpi radialis.

A case has been reported cured by manipulation commenced soon after birth, as we recommend in congenital club foot; reposition and fixation with plaster-of-Paris may be employed, but in our patient I think tenotomy of the contracted tendons is necessary. This I do not think ought to be attempted by the ordinary subcutaneous method, but rather by open incision so that we can see what we are doing and thus avoid injury to important nerves, etc. A curved incision had better be made across the wrist with its convexity upward, thus giving room for the recognition of the particular tendons we wish to sever. These



tendons are very small affairs in so young a child and great care is necessary. To-day I propose to confine myself to operating upon the feet, and as the deformity is of so high a grade I will, after dividing the tendo Achillis, make an open incision on the inner sides of the feet just below the inner malleolus dividing *all* resisting tissues, not forgetting to sever the deltoid ligament. This is practically what is known as Phelps' operation. The operation has been done in a most aseptic manner and now after careful dressing and reposition in a slightly exaggerated degree we will put the feet in plaster casts, these to be removed from time to time as indicated.

The hands were operated upon several weeks later and there is every reason to expect an excellent result.



## TWO CASES OF INTESTINAL SURGERY IN WHICH THE "MURPHY BUTTON" WAS USED.

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When Dr. Murphy called the attention of the profession (*Medical Record*, Dec. 10, '92) to the device originated by him for intestinal anastomosis and end-to-end approximation, it was received with much favor at first, then severely criticised by such men as Senn, Keen and others. But the effect of this criticism was only short-lived, and to-day scarcely a week passes without some one of our medical journals publishing accounts of successful "button" operations by men all over the world. Not only in so-called medical centers, but also in country villages.

It was thought that the metallic tubes might perforate the intestine, that an aseptic necrosis was impossible, and that it was impossible to limit the area of gangrene within the grasp of the button—hence a fatal leakage was probable. Then again, it was said, that the small lumen in the button and its pressure within the bowel constituted grave dangers; besides, marked contraction of the opening was bound to occur.

Dr. Murphy, after a painstaking study of the pathological histology of reunion and an extensive clinical study of his own and other surgeons' work, has, I think, sufficiently demonstrated the great utility of the button, especially for end-to-end approxi-

mation; that the device is ideal, because of the rapidity of execution it affords, and the safety to the patient immediate and remote.

For lateral anastomosis the round button does not seem to be so good, excepting as a temporizing measure, but possibly the oblong button, which produces a large-sized communication, will prove efficient.

As the researches of Magill show a wonderful lessening in the mortality, where, in the same class of cases, approximation plates after Senn's method are used instead of the usual Continental suture method, I believe the saving of time, increase accuracy of approximation, and because of the simplicity of technique required in the use of the Murphy button, the greater the number of surgeons willing to apply the life-saving method, will *again* lower the death rate in most of the intestinal lesions amenable to relief or cure by surgery.

No references is intended in this paper to the advances made in the surgery of the gall-bladder.

I wish to report two cases in which the "button" was used:

CASE I.—A man, 34 years of age, was seen by me for the first time during the night of June 8th, 1894. The following are the notes furnished by his family physician, Dr. W. H. McClanahan, of Omaha, with whom I was associated in the case: "The patient came under my care May 14th, 1894. At that time he had a temperature of 103° F., coated tongue, etc. I found



tenderness in left iliac region; bowels moved, but discharges were soft and unformed.

*“History.*—For several months he had bad pain in the left side, coming on in paroxysms, stools small and flattened. Had used for months the ‘Hall treatment’ for constipation. At first it was satisfactory, but during March, April and May he found he could not retain more than one or two pints of water. When he attempted to take more the pain was intense. Tenderness could always be elicited upon deep pressure in left iliac region.

“By May 21st the fever had entirely subsided and the patient felt fairly well and as he was on a liquid diet he had much less pain than formerly. From May 21st to June 8th his condition remained much the same—there had been no movement of the bowels since June 3d. On June 8th he was taken with intense pain in left side, followed by marked tympanites and complete obstruction.”

When I saw the man, in consultation with Dr. McClanahan, on the night of June 8th. his general condition as to pulse and temperature was fair, but he had that expression of face we all so dread, the so-called “abdominal expression,” he was vomiting and also suffering from hiccough. An abdominal section was advised, and the next day he was taken to the Clarkson Hospital and the abdomen opened. At the time of operation there was no material change from the preceding night and

considering the gravity of affairs, he was apparently in good condition.

The obstruction, a new growth, about the size of a lemon, was found at the upper part of the sigmoid flexure and completely occluded the lumen of the gut, which was greatly distended above the tumor, collapsed below. Even so early in the operation, the heart began to behave badly, and as a resection was deemed out of the question at the time, a temporizing anastomosis to overcome the obstruction was done by means of the large Murphy button. Before this could be accomplished, however, the distension had to be somewhat lessened by opening the colon and evacuating much of its contents. The anastomosis required ten minutes and could have been done in a much shorter time had not a leakage occurred through that part of the button introduced above the obstruction, in spite of the usual precautions. This leakage occurred as the result of the compression of the gut being inefficient because of the immense amount of adipose tissue surrounding it, the man being very corpulent. Before the abdominal incision could be closed, the small intestine had to be opened and evacuated. The man died 26 hours after he left the table, never recovering from the shock added to the condition demanding interference.

Years of experience in abdominal surgery has taught me that we are apt to attempt too much in these cases, when in a critical condition, and I believe the interests of all are conserved by simply

opening the bowel, after having secured it in a suitable incision, awaiting until later, if the patient survive, for more radical surgery, No post-mortem could be had.

It is proper to state that for a number of days preceding my visit Dr. McClanahan had urged the necessity of a consultation with a surgeon, deeming it a surgical case, but could not gain the patient's consent.

CASE II.—Miss N, 20 years of age, family history good, had always been healthy prior to October, 1893, with the exception of one or two attacks of cramps, from which she had suffered yearly for the preceding three or four years—the pain being located in the left iliac region and lasting about one week each attack. From October, 1893, to June 12th, 1894, the date of entrance into hospital, she had been more or less indisposed, still her general health was not markedly deteriorated.

A careful examination showed no organs unhealthy except that a tumor of small size and irregular contour was discovered to the left of the uterus. The tumor was only very slightly movable. Diagnosis as to the exact character of tumor was uncertain, but its origin was thought to be rather ovarian than tubal. On June 13th under ether, the patient being in the Trendelenberg position, the abdomen was opened by the usual incision, and the tumor found to be a very much distended Fallopian tube, with adhesions to the uterus and surrounding intestines, especially the lower portion of the sigmoid flexure of the colon and upper part of the

rectum, the gut wall being infiltrated and studded with tuberculous nodules—the peritoneum covering the small intestine surrounding the tube was also studded in the same manner—there was very little fluid in the peritoneal cavity. In attempting to free the tube from the large gut, in spite of great care, a hole was made into the bowel. Thinking it safer to resect the infiltrated area of gut than to suture the irregular, gaping opening made into it, I did so, uniting the divided ends together by a large Murphy button, and in addition introduced several tension sutures. The resected part of gut removed measured between four and five inches. The whole procedure was extremely difficult, because of the deep situation of the parts involved, and the short sigmoid meso-colon and meso-rectum. The parts next the uterus were so friable, that, ligatures cutting through, long clamps had to be applied and allowed to remain. The whole area involved was carefully packed with iodoform gauze in order to wall off the general peritoneal cavity. Recovery was tedious, a small fecal fistula formed, but changed its character to a simple sinus after the evacuation through the opening, of the silk sutures which had been introduced for the purpose of relieving the tension on the edges grasped within the button. According to the inventor of the button, no tension sutures should be introduced. The button was removed from the rectum on the twenty-third day. The young woman is now well and at work.



The following is the report of the pathological condition found upon microscopical examination of the specimens removed, and was made by Prof. W. R. Lavender, of the Omaha Medical College:

I. *Specimen Bowel with Adjoining Mesentery*.—All coats of bowel infiltrated with tubercular or so-called granulation tissue, a number of giant cells, great proliferation of connective tissue; mesentery showing tubercles with foci of cheesy degeneration.

II. *Specimen of Fallopian Tube Adjoining Uterus*.—Dense infiltration of small cells, a large number of round cells, proliferation of connective tissue and a few giant cells, no cheesy degeneration.

The above results confirm the diagnosis of the case being tubercular.







